RDC/CCB Working Group Recommendation

Prepared by The RDC/CCB Working Group

March 5, 2001

Submitted to Minister of Health and Long-Term Care Tony Clement

PREAMBLE

Throughout North America, hospitals use standards such as redirect consideration (RDC) and critical care by-pass (CCB) in their emergency departments (ED). These standards are implemented to recognize that hospital EDs may be busy at times and require a mechanism to inform ambulance services so that the ED can take the necessary time to deal with demands. It has been recognized in Ontario that these standards need to be refined in order to reflect today's environment.

To that purpose, MOHLTC convened an RDC/CCB Working Group to address some of these issues. Membership of the group included representatives of hospitals, ambulance services and CritiCall and cross representation from teaching, regional and community hospitals.

The Working Group would like to reiterate that their recommendation is not seen as the single answer to all pressures within the emergency system. Rather it is anticipated that the recommendation will enhance the distribution of ambulance patients through better communication. It will complement other initiatives underway through the Emergency Services Strategy and support further initiatives yet to be identified. In developing the recommendation the Working Group worked from the following guiding principles and assumptions:

Guiding Principles:

- Maintain patient safety
- Ensure a destination for every patient
- Allow a safety valve for hospitals when they are overwhelmed
- Restore the public's confidence in the health care system

ASSUMPTIONS:

- Development of a provincial recommendation which allows for local agreements to address specific issues
- Sickest patients will continue to be treated in a timely manner and will go to the nearest destination (this would be modified by the needs of the patient for a specialized service offered at only specific sites)
- The Canadian Triage Acuity Scale (CTAS) provides a consistent measure of patient acuity and in triage in hospitals and allows for a patient focussed approach
- Current protocols for trauma cases would be maintained and all trauma cases would go to the nearest trauma centre as per current protocols (e.g. trauma, burns, paediatrics)
- Hospitals have their own internal disaster plans that address extreme situations (e.g. bomb threats, floods, major chemical spills etc...)

- There will continue to be times when an ED is busy and/or there may be an influx of ambulance units
- The recommendation will not resolve pressures felt by either the ambulance service or the emergency department but will enhance communication.

Recommendation

The Working Group recommends that the current Redirect Consideration (RDC) and Critical Care Bypass (CCB) be replaced with the following.

1. Implement the Canadian Triage Acuity Scale (CTAS) for all providers including ambulance services.
2. Eliminate CCB.
3. Replace RDC with a category which is based on the CTAS levels of patient acuity. This will allow hospitals to alert others, particularly the ambulance dispatch centre, to their pressures
4. Enhance communication between hospital and ambulance in relation to hospital status through the use of CTAS to convey the patient status and the hospital's ability to take different levels of patients.
5. Track disposition of ambulances to hospital in real-time, using the CTAS tool, through CritiCall. The CritiCall screen will also permit a fan-out message from the dispatch centre indicating when, due to emergency demands, routine ambulance transfers will be deferred.
6. Local agreements may be developed to address issues specific to their jurisdictions within the framework of the patient priority system.

Each of these elements would work together to allow for a common language to be used by providers (i.e. ambulance services, dispatch and hospitals) that will further enhance communication between providers. In turn this will focus attention on the patient's acuity, which will allow for appropriate distribution of ambulance patients to receiving hospitals. CTAS is an internationally recognized five level triage tool to assess patients in emergency situations.

It is important to note that paramedics and emergency medical attendants in the field applying CTAS to indicate patient severity prior to transport is different than the complex process of triage done in the ED by triage nurses. The assignment of acuity by paramedics and emergency medical attendants is intended to improve communication, and decisions about transport and destination.

Implementing CTAS will continue to ensure that patients arriving by ambulance will go to the most appropriate hospital. It is important to note that between 7 and 20 per cent of all emergency visits arrive by ambulance. The remainder arrives by other means.

The current CritiCall system would be further refined so that real-time information is available on the current distribution of ambulances to various hospital sites along with hospitals' status. This will be of assistance to the dispatch centre, which continues to have overall responsibility for the direction of ambulances. It is important for all providers to ensure that the information available is both timely and accurate.

CritiCall will also include a validation tool that will be completed prior to hospital changing their status. This will allow for enhanced planning at all levels. As noted above, most ED patients do not arrive by ambulance. The CritiCall system will be modified so that the activity of the entire department can be captured. It is recognized that development of information systems within the ED will promote planning.

Each of these points will facilitate a better co-ordinated system that would ensure that each patient has an appropriate destination, and provides for a better distribution of the patients across the system.

Benefits/Limitations

It is important to reiterate that, as noted in the preamble, the recommendation of the Working Group is not intended to be a response to all pressures on the Emergency Services System. It is intended to further enhance our current system to be more reflective of the current environment and enhance communications between providers.

It is acknowledged that there are many factors that put pressure on emergency services. Some factors are related directly to the hospital ED, like staffing, and others are related to other system pressures such as bed capacity and restructuring. Over the past few years, government has provided funding on a number of different initiatives to alleviate pressures in the short to medium term to address immediate concerns. In the longer term initiatives such as additional long-term care beds, telecare, and primary care reform continue to be implemented. The Working Group encourages the government to continue its focus on supporting EDs across the province.

Consultation

The Working Group consulted extensively across the province, meeting formally with fifteen groups representing ED nurses, ED physicians, administrators, ambulance services, and municipalities. In addition numerous individuals provided feedback directly to members of the Working Group and through letters to Ministry staff. Their excellent comments and questions have enriched this final report.

The overall support for the recommendation from stakeholders across the system was gratifying and supports the Working Group's recommendation to proceed with this initiative. As with any consultation there were useful questions raised, none of which suggested any negative impacts on patient care. The Working Group is committed to continue to discuss issues raised by those with concerns.

IMPLEMENTATION

The Working Group recommends that the Patient Priority System, as outlined above, be implemented in a phased manner which will allow for appropriate evaluation. The Working Group supports the involvement of the Institute for Clinical Evaluative Sciences (ICES) and others in that process. The introduction of the system in phase one to communities which reflect the make-up of Ontario's emergency services system is important so as to ensure that all Ontarians will benefit from this improved communication approach.

It is important the system, when mature, be used across the province so as to ensure consistency and clarity. However, the Working Group believes that there is room within the system for "fine tuning" which will reflect local realities.

Appendix 1

RDC/CCB Working Group Membership

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Canadian Triage Acuity Scale

The Canadian Triage Acuity Scale (CTAS) is a standardized emergency patient prioritization tool which is used by hospital emergency departments and operators to ensure that emergency patient care decisions are well communicated and emergency services effectively utilized.

The system utilizes five levels of classification, with Level 1 being the most serious and Level 5 being the least serious. The type and level of emergency care that an emergency patient receives is determined by both their condition and the on the scene assessment of their medical needs by trained emergency service providers.

Level 1- Resuscitation

This type of emergency patient is someone who is suffering from either severe respiratory distress and or unconsciousness resulting from a major trauma. Typically the patient is unresponsive with either unstable or absent vital signs. The patient is deemed to be suffering from conditions that are a threat to life and/or limb requiring immediate aggressive intervention.

Level 2 – Emergent

Conditions that fall into this category pose a potential threat to life and/or limb and require rapid medical intervention. This emergency patient type could be suffering from such symptoms such as but not limited to an agitated mental state, chest pain, abdominal pain, symptoms associated with diabetes, some head pain or trauma or high fever (especially in children) marked with other ailments such as vomiting and/or diarrhea.

Level 3 – Urgent

Conditions could progress to a serious problem requiring emergency intervention. These patients may be suffering from serious discomfort and/or an interruption in their daily living routine. Examples of symptoms may include but are not limited to head pain, chest pain, mild to moderate asthma, mild to moderate bleeding and any symptoms associated with dialysis.

Level 4 – Less Urgent

Conditions that are related to patient, age, distress or potential for deterioration. Symptoms could involve, but are not limited to, chest pain, head pain, back pain, abdominal pain, and depression.

Level 5 – Non Urgent

Conditions that may be acute but non-urgent as well as conditions that are part of a chronic problem with or without evidence of deterioration. Intervention can be delayed and/or referred to other areas of the health care system. Symptoms can be but are not limited to minor trauma, emotional distress, sore throat, and abdominal pain

Source: Ministry of Health and Long-Term Care

Appendix 3

Consultations

Geographic

- Central East Region
- Halton Peel
- Hamilton
- Kingston
- Niagara
- Ottawa
- Southwest Region
- Toronto
  - Central Network
  - East Network
  - West Network

Other

- Emergency Room Nurses, Hamilton
- Emergency Nursing Directors
- Land Ambulance Implementation Steering Committee/ Association of Municipalities of Ontario
- Ontario Nurses Association